

EXHIBIT-10

BAPTIST HEALTH  
0628

COOPER, DAVID  
B0609400139  
B000079236

PATIENT VERIFICATION DATA:  
COOPER, DAVID- 0609400139

DATE OF STUDY:

REASON FOR STUDY:

Chest pain. History of aortic valve replacement.

REQUESTING PHYSICIAN:

Dr. Ahmed.

The quality of this study is fair.

M-MODE MEASUREMENTS:

1. LV end diastolic diameter = 59 mm (increased).
2. LV end systolic diameter = 20 mm (normal).
3. Posterior wall = 15 mm (increased).
4. Septal wall = 15 mm (increased).
5. Aortic root diameter = 39 mm (mildly increased).
6. Left atrial end systolic diameter = 44 mm (increased).
7. Hence, by M Mode there is evidence for LVH, left atrial enlargement, and mild aortic enlargement.

DOPPLER FLOW/COLOR MAPPING ANALYSIS:

1. LVOT velocity is not readily measured.
2. The peak velocity across the aortic prosthetic valve is about 4 m/s which is elevated.
3. There is moderate AI by color flow mapping analysis. This is certainly more than what is expected from a prosthetic valve. Hence, I believe there is a possibility of prosthetic valve dysfunction, suggest TEE.
4. Mild MR is noted.
5. Mild TR is noted.

VALVE FUNCTION:

1. The prosthetic valve is seen, very difficult images, obviously in transthoracic study. The leaflet appeared to be thickened.
2. The mitral valve is mildly thickened.
3. The tricuspid valve is normal.
4. Pulmonic valve not well seen.

CHAMBER AND FUNCTION:

1. There is mild to moderate concentric LVH.
2. EF of the left ventricle is about 50% to 55%, which is lower limits of normal.
3. Apex is severely hypokinetic. This does suggest abnormal regional wall motion. In addition, the mid distal anterior wall is also hypokinetic. The rest of the wall contracts normally.
4. The right sided chambers are normal.
5. No pericardial effusion.

(CONTINUED)

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